ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Rt Hon Amber Rudd MP** **Home Secretary** **Direct Communications Unit** **2 Marsham Street** **London SW1P 4DF** 2. **Dorset Health Care University** **Trust Headquarters** **Sentinel House** **Nuffield Industrial Estate** **Nuffield Road** **Poole BH17 0RB** 3. **Care UK** **Connaught House** **850 The Crescent** **Colchester Business Park** **Colchester CO4 9QB**
1	**CORONER** I am Dr Elizabeth Ann Earland, Senior Coroner, for the coroner area of Exeter and Greater Devon.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 8th January 2014 I commenced an investigation into the death of Stephen Mark SHAYLOR, 42. The investigation concluded at the end of the inquest on 8th December 2017. The conclusion of the inquest was: Cause of Death: 1a Hanging The Deceased was arrested for drugs offences on 28th December 2013 and detained at Exeter Custody Centre before attending and being sentenced at Exeter Magistrates Court on 30 December 2013 before being sent to HMP Exeter on the evening of 30th December 2013. He was seen by substance Misuse Team and placed on a drug stabilisation regime, in a shared cell on main wing. He hanged himself and was found at 03:05 on 1st January 2014. He was not considered for S/H with a ACCT document, but

	was subject to Healthcare night welfare checks. The check at 02:00 1/1/14 was not done. Whilst the Jury felt the (failure to) position the prisoner on a stabilisation landing was not causative of the death, the inadequacy of the Healthcare night welfare checks may have been a factor. There was no system of continuous CCTV monitoring in the cells.
4	**CIRCUMSTANCES OF THE DEATH** PMH - prev IVDU, moderate tricuspid regurg, ?renal function compromised On evening of 30/12/13 was placed into cell A230 at HMP Exeter which was already occupied by another inmate. He was seen by Healthcare and put on a stabilisation regime by prison doctor for his drug habit. This involved a system of Night Welfare Checks at 23:00, 02:00, 05:00. Very little conversation took place. 31/12/13 he spent the day on the wing, cell was unlocked for most of the day, but not known if he left the cell as his cell mate was out on the landings for much of the time. They did watch TV in the cell together for 3-4hours. Approx. 1745hrs they ate together in the cell. Approx. 1800hrs cell locked for the night, they watched TV lying on their bunks but didn't talk, he was on the top bunk. Late in the evening he got down and sat at table, cell mate turned to face the wall and went to sleep. Cell mate woke in the early hours to find cell light off, but TV still on and as he got up to turn off TV he could see him hanging from the window bar. He was fully clothed with a ligature made from torn green cotton bedsheet wrapped twice around neck. Prison staff alerted, healthcare cut him down and commenced CPR. Paramedics attended and death recognised 0335hrs 1/1/14 but the Deceased had been dead for some time. CID and SOCO attended. 'Suicide' note found in the cell. An Investigation was opened on 9th January 2014.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. **MATTERS OF CONCERN** (1) There were 38 places available on a corridor in C4 wing as a stabilisation wing for dealing with inmates subject to Healthcare night welfare checks. Head of Residence and Safety told the Court that the Prison received between 60 – 80 inmates per week needing detox and requiring placement in C4 cells which had doors with larger windows for checking patients at night. (2) Professor Wall, substance misuse expert, said that the system for looking after these inmates was not fit for purpose and that healthcare night welfare checks (looking through a hatch in a cell door) were inadequate because it was not possible to ascertain if a prisoner was breathing/alive by this method. (3) Night welfare checks and observations on an ACCT document are at best intermittent and only continuous CCTV monitoring could spot a prisoner self-harming.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th February 2018. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: The family of Mr Shaylor [redacted] I have also sent it to [redacted] who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**[DATE]** 18th December 2017 **[SIGNED BY CORONER]**